PRINTED: 08/21/2012 FORM APPROVED

	R MEDICARE & MEDIC				OMB NO. 0938-0391		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155669	B. WING		07/10/2012		
NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
K0000							
	Licensure and Q Walk-thru Surve Indiana State De	r: 011046 rr: 155669	K0000	Preparation and/or execution of this plan of correction in gener or this corrective action in particular, does not constitute admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	ral, an is e		
	At this Life Safe Riverview TCU compliance with Participation in 1 CFR Subpart 48 Fire and the 200 Fire Protection A Life Safety Code	ety Code survey, was found not in Requirements for Medicare/Medicaid, 42 3.70(a), Life Safety from 0 edition of the National Association (NFPA) 101, e (LSC), Chapter 19, Care Occupancies and		This plan of correction constitution our credible allegation of compliance with all regulatory requirements. Our date of compliance is:	ites		
	of a fully sprinkl to be of Type I (facility has a fire smoke detection	decated on the fourth floor lered building determined (332) construction. The ealarm system with in the corridors and in all ecorridor. The facility					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

(X6) DATE

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155669		A. BUILDI B. WING		<u>01</u>	COMPL 07/10/	ETED		
	NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE		
	does not have smoke detectors in resident sleeping rooms. The facility has a capacity of 25 and had a census of 9 at the time of this visit.							
	The facility was found in compliance with the state law in regard to sprinkler coverage and was found not in compliance with the state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/11/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J0MS21

Facility ID: 011046

If continuation sheet Page 2 of 8

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
	155669		B. WING		07/10/2012		
		_	STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	NAME OF PROVIDER OR SUPPLIER			ESTFIELD RD TCU			
RIVERVIEW TCU			NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
K0032 SS=F	Not less than two other, are provide section of the beexits may be a language of the provided that the adjacent smoke stairwells. The stairwell that do discharge direct on interview at a cknowledged evision of the beexits of the adjacent smoke stairwells. The stairwell that do discharge direct on interview at the acknowledged evision of the provided to the provide	vation and interview, the ensure 2 of 2 smoke vere provided with at leasting a continuous path of discharge. This deficient all occupants in the exact actions with the turing a tour of the facility to 10:55 a.m. on CU has two emergency is a horizontal exit into toke compartment. The compartment has two exit second exit is an exit es not connect to an exit ly to the exterior. Based the time of the	K0032	K 032 It is the practice of this Unit to abide by the Life Safety Code determined appropriate this Unit. 1. What corrective action(s) will be accomplished those patients found to have be affected by the deficient practice. This provider completed an assessment by Fire Safety Evaluation System (FSES) to demonstrate equivalent compliance. NOTE: UPDATED FSES ATTACHED 2. How other residents having the potential to be affected by same deficient practice will be identified and what corrective actions(s) will be taken; All residents located on the 4 th floor have the potential to be affected this alleged practice 3. What measures will be put place or what systemic change will be made to ensure that the deficient practice does not reconstruction to ensure the the deficient practice does not reconstructed to evaluate the safety of these exits. FSES audit will be completed where structural changes are made this Unit. 4. How the correct action(s) will be monitored to	for for een ce; the into		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J0MS21

Facility ID: 011046

If continuation sheet Page 3 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155669	A. BUILDIN B. WING		01 	COMPL 07/10/	ETED
NAME OF F	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					ensure the deficient practice we not recur, The Administrator and or designee will audit safety inspection forms for these stairwell exits to determine safe means of egress 5 times per week for 3 days then 5 times per month for 150 days then 3 times per month for 180 days to total 12 months of monitoring. Result of the audits will be reported QA monthly for 12 months. After 100% compliance is reached the QA committee we determine the frequency of continued monitoring. The Hospital will up dated FSES survey when any life safety structural changes are made this area. 5. What date the systemic changes will be completed. These systemic changes will be completed by 8/2/2012	30 2 ts to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J0MS21

Facility ID: 011046

If continuation sheet

Page 4 of 8

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 01			COMPLETED	
	155669		B. WING 07/10/201			07/10/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
DIVEDVIEW TOLL				395 WESTFIELD RD TCU			
RIVERVIEW TCU				NOBLE	SVILLE, IN 46060		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
K0034	NFPA 101						
SS=F		ODE STANDARD					
		nokeproof towers used as					
	exits are in acco	rdance with 7.2. 19.2.2.3,					
	19.2.2.4		17.00	.2.4		00/02/2012	
		ation and interview, the	K00	134	K 034 It is the practice of this	08/02/2012	
	facility failed to	provide a continuous			Provider to abide by the Life Safety Code determined		
	protected path of	travel to an exit			appropriate for this Unit. 1.		
	discharge for 3 o	f 3 exits in accordance			What corrective action(s) will be		
	_	ns 7.2.3.5. LSC 7.2.3.5			accomplished for those patient		
		nokeproof enclosure shall			found to have been affected by		
		•			the deficient practice; This		
	discharge into a public way, into a yard or court having direct access to a public way,				provider completed an		
					assessment by Fire Safety		
	_	ssageway. Such exit			Evaluation System (FSES) to		
	passageways sha	ll be without openings			demonstrate equivalent	_	
	other than the en	trance from the			compliance. NOTE; UPDATE	ט	
	smokeproof encl	osure and the door to the			FSES SURVEY ATTACHED 2. How other residents having		
	outside vard, cou	art, or public way. The			the potential to be affected by		
		shall be separated from			same deficient practice will be		
		the building by a two			identified and what corrective		
		• •			actions(s) will be taken; All		
		ce rating. This deficient			residents located on the 4 th		
	-	ll occupants in the			floor have the potential to be		
		residents, staff and			affected this alleged practice		
	visitors.				3. What measures will be pu	ıt	
					into place or what systemic		
	Findings include	:			changes will be made to ensur		
	_				that the deficient practice does not recur; Systemic change		
	Based on observations with the				include Quality Assurance		
		ring a tour of the facility			environmental tours will be		
	from 10:30 a.m.	_			conducted to evaluate the		
					safety of these exits. FSES		
	-	orth floor on which the			audit will be completed when	1	
		s divided into two smoke			structural changes are made		
	compartments an	nd has three stairwell			this Unit/ or as requested.		
	exits. Additiona	lly, the fire resistance			4. How the corrective action(s		
		e exit enclosures on the			will be monitored to ensure the	;	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J0MS21

Facility ID: 011046

If continuation sheet Page 5 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155669	A. BUILDING B. WING	<u>01</u>	COMPLETED 07/10/2012		
NAME OF PROVIDER OR SUPPLIER RIVERVIEW TCU			STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	discharge door is Based on intervie observation, the acknowledged ea discharge passag	Administrator ch of the three exit eways are not separated ler of the building by a		deficient practice will not recur The Administrator and or designee will audit safety inspection forms for these stairwell exits to determine safe means of egress 5 times per week for 30 days then 5 times per month for 150 days then 3 times per month for 15 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. The Hospital will up dated FSES survey when any life safety structural changes are made this area. 5. What date systemic changes will be completed. These systemi changes will be completed b 8/2/2012	to the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J0MS21

Facility ID: 011046

If continuation sheet Page 6 of 8

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 01			COMPLETED	
		155669	B. WING 07/10/2012			2012	
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			395 WESTFIELD RD TCU				
RIVERVIEW TCU			NOBLESVILLE, IN 46060				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K9999							
	State Findings		K99	999	K9999 It is the practice of this		07/27/2012
					provider to abide by Environme		
	3.1-19 ENVIRO	NMENT AND			and Physical Standards 1. W	nat	
	PHYSICAL STA				corrective action(s) will be accomplished for those patient	to	
					found to have been affected by		
	2 1 10/00 4 1 1	41. Carilla - 11. and - 1			the deficient practice; Smoke	,	
	` ′	th facility licensed under			detectors will be installed in		
		le must do the following:			each patient room 2. How		
	(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.				other residents having the		
					potential to be affected by the		
					same deficient practice will be		
		ic sprinkler system is not			identified and what corrective		
	` '	out the health care			actions(s) will be taken; All		
	_				residents located on the 4 th		
	_	ly 1, 2010, submit before			floor have the potential to be		
	July 1, 2010 a pla	an to the department for			affected this alleged practice		
	completing the ir	nstallation of the			3. What measures will be pu	ut	
	automatic sprink	ler system before July 1,			into place or what systemic		
	2012.	•			changes will be made to ensur that the deficient practice does		
	(3) Have a hatter	y operated or hard-wired			not recur; Systemic change		
	` '	n each resident 's room			include Quality Assurance	,0	
					environmental tours will be		
	before July 1, 20	12.			conducted to evaluate the		
					safety of these patient rooms	3.	
	This State Rule h	as not been met as			4. How the corrective action		
	evidenced by:				will be monitored to ensure the)	
	Based on observa	ation and interview, the			deficient practice will not recur	,	
		install smoke detectors in			The Administrator and or		
	_	rooms before July 1,			designee will audit safety		
		ient practice could affect			inspection forms for patient		
		•			room 5 times per week for 30		
	9 residents in the	racility.			days then 5 times per month		
					for 150 days then 3 times per		
	Findings include	:			month for 180 days to total 12		
					months of monitoring. Result of the audits will be reported		
	Based on observa	ation with the			QA monthly for 12 months.	w	
Based on observation with the		1		was inclining for 12 inclinis.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J0MS21

Facility ID: 011046

If continuation sheet Page 7 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER: 155669	A. BUILDING B. WING	01	(X3) DATE COMPI 07/10	LETED		
NAME OF PR	OVIDER OR SUPPLIER W TCU		STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD TCU NOBLESVILLE, IN 46060					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE ROPRIATE	(X5) COMPLETION DATE		
	Administrator du from 10:30 a.m. 07/10/12, smoke installed in resid Based on intervious observation, the acknowledged si	to 10:55 a.m. on detectors are not ent sleeping rooms.		After 100% compliance reached the QA committed determine the frequency continued monitoring. What date the systemic completed. The systemic changes will be completed by 7/27/2012	is tee will y of 5. hanges ese			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J0MS21

Facility ID: 011046

If continuation sheet

Page 8 of 8